Ellie Mother 26 years 18a Flower Street

Toby Subject 2 years 18a Flower Street

Larry Ex-partner 42 years No fixed abode

Ellie’s doing really well. There’s a history of substance misuse but she has now been clean for 18 months. The health visitor reports the house is now clean and tidy, and there have been no reports of domestic abuse or rough handling of Toby. Toby has been seen regularly by the health visitor and there have been no concerns about accidents or bruising.

With the support of professionals Ellie separated from Larry 5 months ago, just after the first review conference. She accepted her chastisement of Toby had been slightly over the top, and she has been working with us attending all her sessions and agreeing to see the domestic abuse worker. There was some confusion over the first visit but Ellie explained she had no credit on her phone.

Toby’s nursery were struggling with him and relationships with Ellie broke down when they confronted her about being repeatedly late. We’ve supported Ellie to identify a new nursery and they’ve been more flexible. We’ve recorded the old nursery’s concerns on file, but there have been no issues since the move.

Ellie has had to cope with repeated victimisation from the neighbours on the estate. They have made 4 allegations about Toby being out late. Ellie has recognised she has made life difficult for herself with her previous behaviours, and has worked to build bridges with the neighbours, offering babysitting and shopping errands. This has not been offered in return, but Ellie’s been undaunted. Equally, she has worked to become more independent and has ended contact with her mother. She feels her mother was always critical and has really found herself since she has stood on her own two feet.

I have seen Toby on each visit (2 visits since taking on the case 3 months ago – case had been unallocated for 2 months after agency worker left) and he has been smiling and happy with his mum. He is too young to have wishes and feelings.

The professionals at the last core group no longer have the concerns they had at the last conference as Larry has now left the home. I discussed this case in supervision when taking on the case, and it was acknowledged by my manager the concerns had diminished.

**Professional Dangerousness**

**Key examples of professional dangerousness**

1. **Rule of optimism:** Professionals tend to want to believe that all is well for the child. Even when the indicators of abuse are visible there is a tendency to explain them away and be convinced that the child is safe. This is a form of denial and probably the most common form of dangerous practice. In one case the social worker saw the child looking sick but afterwards saw her with the family on an outing. He allowed himself to believe the latter to be proof of the child’s safety and thought his original concerns to be unfounded.
2. **The Stockholm syndrome:** This theory is based on hostage situations where the people taken hostage begin to identify with the cause of the terrorists. It is a survival mechanism common in child abuse cases. Sometimes a parent or abuser is powerful and intimidating, perhaps critical of professionals and the worker will begin to see the adult’s point of view rather than the child’s. It is one way that the worker feels safe at the expense of the vulnerable child.
3. **Professional accommodation syndrome:** The worker may mirror the child’s retraction of abuse, deny the reality of the abuse and be keen to be persuaded that any allegation by the child must be suppressed. Any other possible reason for the abuse will tend to become accepted in preference to considering the possibility that abuse has occurred.
4. **Exaggeration of hierarchy:** Adults of low status who report abuse may not be heard or taken seriously even though they may be close to the child eg neighbours, friends or a nursery worker. A psychiatrist, lawyer or paediatrician will probably get their important opinions heard more readily by other professionals. In one child abuse scandal the cook in the children’s home had a wealth of information about the child abuse taking place but was not interviewed by the inquiry.
5. **Concrete solutions:** Professionals respond swiftly to abuse situations with practical solutions such as housing, washing machines, or money rather than by investigating and attempting to verify the alleged abuse.
6. **Assessment paralysis:** Sometimes professionals feel helpless and incapacitated. It might be thought that change is hard to achieve because the family have always lived in an abusive way and it is just their way of life. Chronic neglect and inter-generational sexual abuse are often ignored because of this attitude.
7. **Stereotyping**: Professionals may make assumptions about how families bring up their children. These may include cultural stereotypes. In one case the stereotype of the black grandmother being able to cope with every situation falsely portrayed her as a protector of the child against a powerful and abusive adult within the family.
8. **False compliance:** Parents may be able to convince professionals that they are cooperating to protect the child but in fact a skilled practitioner who can analyse parental behaviour will be open to considering the possibility of them being abusive.
9. **Omnipotence:** Professionals believe that they know the best interest of the child and will not revisit their perceptions in the light of new evidence.
10. **Closure:** Families may shut out professionals. Calls go unanswered, appointments are missed, curtains are closed and doors locked. Child deaths from abuse are often preceded by closure. This dynamic may be mirrored by professionals avoiding contact with the family.
11. **Role Confusion:** Professionals may be unclear about tasks and assume that someone else is responsible for protecting the child. In child protection everyone has prime responsibility for the safety of the child. Clarity of decisions is essential. In one case a health visitor said she would see the baby and the social worker assumed that the health visitor was visiting the home. Instead, she was seeing the baby at the clinic and no-one saw the appalling conditions in the home.
12. **Children unheard of parent and carers unheard:** Every child abuse inquiry highlights the central importance of listening to the child. Although children do find it hard to speak of abuse it has been shown that prior to a child’s tragic death they have often forewarned someone in authority about the risk. Similarly prior to fatally harming a child, carers often raise the alarm by telling a professional that they are afraid of hurting the child or they cannot cope.
13. **Information which is emotional, recent and vivid takes precedence over the old:** Inquiries inevitably dem onstrate that there was, among agencies, a great deal of knowledge and understanding about actual or potential harm to the child. New information must be examined in the context of prior facts. The importance of chronologies to allow analysis cannot be over emphasised. This information must be transferred as a family moves between authorities. This is sometimes referred to as the Start Again Syndrome which prevents practitioners from having a clear understanding of a case based on past information (Brandon *et al*, 2008:11)
14. **Non-compliance with statutory procedures:** Inquiries commonly report that legislation, policy and practice are sound but that professionals did not comply with their implementation. When child protection procedures are in place such as conferences and strategy meetings, children generally become safe. Formal procedures allow for collation and analysis of all available information.

**Additional messages about professional dangerousness from Serious Case Reviews.\***

1. **Overwhelmed professionals and organisational capacity:** The ‘health’ of agenciesand their capacity to deal efficiently and effectively with the volume and demands of safeguarding children work. Includes strain in front line workers ; lack of fully staffed fully supported workforce; frequent and confusing changes in practitioners and managers; high sickness levels; no continuity of service; delay; overwhelmed workers may not grasp complexity and make good professional judgements.

*(interacts with 1) hostile families to produce low expectations and low energy and 2) chaotic, overwhelmed, unsupported families 3) false compliance*

**16. Professional confidence and uncertainty:** leads to struggle to challenge decisions and behaviour of their multi agency colleagues when they feel the child is at risk;

*(interacts with Exaggeration of hierarchy; non-compliance with statutory procedures; role confusion (assumption others dealing) and efforts not to be judgemental)*

**17. Efforts not be judgemental becoming failure to exercise professional judgement :** keenness to acknowledge successes of disadvantaged adults using their services – deficits missed.

*(interacts with to professional confidence; hostile families)*

**18. Silo Practice:** failure of professionals to look at the child’s needs outside their specific brief

*(interacts with to lack professional confidence, efforts not to be judgemental; overwhelmedness)*

**19. Fixed views:** view or mindset is formed and becomes fixed/rigid. Examples:

‘Neglect case mindset’ ;‘Rough handling’ Men as ‘good dads’ or ‘bad dads’ – rather than fully assess their history/profile/parenting.

*(interacts with omnipotence, silo practice, not being judgemental, overwhelmed professionals)*

**20. Inconsistent and inadequate supervision:** complex stressful work requires regular, knowledgeable supportive, reflective, analytical supervision where planning also takes place. (interacts with overwhelmed professionals, silo practice and fixed views

*(interacts with false compliance, overwhelmed professionals ,levels of cooperation, rule of optimism,non compliance with procedures, role confusion, children unheard)*

**21. Lack of authoritativeness :** Parents/carers needing to be challenged and confronted about poor parenting, targets set and timescales with a tight interagency grip on and ownership of the intervention/ plans.

(interacts with false compliance, efforts not to be judgemental; supervision, fixed views)

**22 Threshold of intervention:** A pattern from SCRs - 53% receiving Children’s Services intervention, 12-18% CP Plan, therefore 47% with additional needs or universal services. Laming said “child protection does not come labelled as such”. Need to be aware of risks across all levels of need. Also questions of how to get sufficiently qualified staff at all levels of intervention .

*(Interacts with overwhelmed professionals and organisational capacity, fixed views, disguised compliance, levels of cooperation)*

**23. Co-morbidity of parental substance misuse, parental mental ill health, domestic violence and poor living conditions:** While the presence of these factors does not predict abuse, they do increase the risks of harm to the child and often present a hazardous, and frightening home life for the child and a toxic caregiving environment. Risk assessment needs to get to grips with this with good questionnaires and inter-agency working)

*( Interacts with false compliance, overwhelmed professionals, fixed views, silo thinking, efforts not to be judgemental, lack of authoritativeness)*

**24. Overwhelmed chaotic families: ‘**negative’ family support, drugs, violence, mental ill-health, criminality, numerous moves; fires and other accidents.

*(interacts with overwhelmed professionals and organisational capacity)*

**25. Levels of Cooperation:** - cooperation and high cooperation, it is not a spectrum. Some family members may cooperate, others not and it can change quickly. Some families cooperate with some agencies, not others. As well as being separate dynamics, families can and do mix passiveness and aggression as a resistance pattern. Remember professionals can provoke cooperation/hostility as well as diffuse it by positive engagement skills. While with good cooperation there is a chance that the child may be seen but harm go unnoticed, there is a danger that with hostile families, services might be withdrawn, children become more isolated/unprotected, families move/go missing.

*(interacts with overwhelmed professionals, co-morbidity, lack of authoritativeness, disguised compliance)*

**26 Care and control conflicts:** Parents’ own childhood experiences of adverse parenting leave them with unresolved conflicts that spill over into relationships in adult life with partners, children and society. Conflicts about: being cared for/ caring for others and /or self control, wish to control others, or fear of control by others

*(interacts with Co-morbidity (25 above), levels of cooperation, children unheard, )*

\*Sources:1. Understanding Serious Case Reviews and their Impact A Biennial Analysis of Serious Case Reviews 2005-7. UEA/DSCF. Marian Brandon et al 2000. 2.Serious Case Review : Baby Peter. Executive Summary February 2009 LSCB Haringey.

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